6. ENROLLMENT PROCESSES

Introduction

This section describes the processes for statewide managed care enrollment. It includes many enrollment procedures which are currently conducted in the three metropolitan areas operating under the State's 1915(b) waiver. However, it also contains a number of new features which will be adopted in MCO service areas for the 1115(a) demonstration, and includes all rural enrollment procedures.

Enrollment Process for MCOs

Many features of enrollment for the State's current managed care program, operated under the 1915(b) waiver, will also be included under the 1115(a) demonstration. Currently, all applicants for certification and re-certification are able to obtain materials during face-to-face interviews with DHS social workers. However, under the demonstration, only applicants for initial certification will receive materials during the application interview. Other clients will receive enrollment information through mailings from the Authority. Both processes are described below.

Under the current system and at initial certification interviews under the demonstration, applicants are given the opportunity to enroll in ***SoonerCare*** and select an MCO and primary care provider at the time of eligibility application or recertification. Applicants meet face-to-face with a case worker who provides information describing the ***SoonerCare*** program, MCO and primary care provider options. During this session, the case worker stresses to applicants that actual enrollment into an MCO will not occur unless and until a positive eligibility determination has been made.

The State provides information and educational materials to members regarding the managed care program and participating MCOs to assist them in making a decision (for additional information regarding the contents of enrollment and educational materials, see section 5). For the AFDC population, families are required to select one plan for all eligible members (exceptions to this policy are noted below). Under the 1115(a) demonstration, individuals/families who select an MCO, will be permitted to disenroll from the plan (change plans) in the first month, during the open enrollment period or at any time for good cause

Individuals who do not desire to make a selection at the time of application are given a toll-free Member Services telephone number to call if and when they are ready to choose. The State has contracted with Benova, Inc. for this service in the 1915(b) program, and will continue to use them for the 1115(a) implementation.

Benova has 13 years of experience as a Medicaid enrollment agent, and is currently providing similar assistance in California, Oregon and Connecticut. The Benova

telephone staff are trained to answer any questions on the *SoonerCare* program and assist beneficiaries in completing the selection process over the phone. Spanish-speaking operators will be available for applicants who speak Spanish as a first language, and translation services will be available to assist applicants who speak languages other than English and Spanish. A TDD system will also be available for persons with impaired hearing.

The State monitors the effectiveness of its telephone enrollment agent via daily reports from Benova. These reports detail the number of telephone call received by type (information only, enrollment requests, complaints), averages by amount of talk time, calls by operator and time received. When complex issues arise which Benova is unable to address, a toll-free number for the Authority is given to clients for contacting the Authority's Member Enrollment Unit.

Applicants can also select an MCO by marking their choice on a pre-addressed postage paid enrollment card included in the enrollment packet and returning it to the State. The State believes that by offering several methods for health plan selection, it will minimize the number of cases in which individuals do not make a choice.

Regardless of the method used, all individuals are required to select an MCO and inform the State of their choice within ten business days of their application for eligibility or recertification. Those who do not select will be assigned automatically to **an** MCO based on a pre-determined assignment algorithm developed by the State and its consulting actuaries (the algorithm is described in the health plan RFP previously shared with HCFA). For those members who do not select an MCO or who are autoassigned, the MCO will assign a PCP. The member can change PCPs within **30** days if not satisfied with the choice. How?

The State informs beneficiaries of their MCO and effective date by mail when eligibility is granted or recertified. MCOs are also notified through daily electronic data transmission. For individuals whose eligibility is determined before the 15th day of the month, their MCO enrollment will become effective at the beginning of the following month. Members whose eligibility is determined the 15th day of the month or later will be enrolled on the first day of the second month after determination. Prior to the MCO effective date, any eligible Medicaid recipient may accesss covered services through the Fee-for Service system.

Upon receiving notification of a new member, the MCO is required to mail out a member handbook and inform the member about his or her primary care provider options and how to make a selection if that member **has** not already done so. The MCO is also required to issue a permanent identification card within 10 days of enrollment to all members, which meets the standards and specifications of the State. The card must include:

- Name of MCO
- Member's name
- Medicaid identification number
- Issuance Date
- PCP name and clinic affiliation, if applicable
- PCP telephone number
- Toll-free telephone number to be operated by the MCO, 24 hours/7 days per week
- Instructions regarding obtaining emergency and urgent care

Special Enrollment Provisions

Once enrolled into an MCO, members are permitted to change MCOs within thirty days of enrollment, without cause. Under the 1915(b) waiver, members may also change MCOs once in every thirty-day period. However, under the 1115(a) demonstration, once the thirty day window has expired, members will remain enrolled in the MCO unless:

- They lose eligibility
- They change health plans during the next open enrollment period
- They are disenrolled for cause
- They move out of the urban health plan service area

If a member moves from one urban MCO service area to another, he/she will be automatically enrolled in the same plan, if it exists in the new area. The plan will contact the member to select a new primary care physician. If the member moves from an MCO to a partial capitation area, he/she will be autoassigned to a provider based upon travel times and provider capacity. The member will be able to change providers/networks within 30 days if the assignment is not acceptable.

Under the 1115(a) demonstration, enrollment for clients other than those being certified initially for the program, will be conducted by mail during an open enrollment period held once every twelve months. During the open enrollment period, enrollees will be given the opportunity to remain with their previous MCO (assuming it contracts with the State for the upcoming year) or select a new MCO from among those being offered. If the member does not select a different plan, he or she will automatically remain in the current plan, with no interruption of coverage.

During the May, 1996, open enrollment period, the State will mail an enrollment packet to all eligible clients in the three MCO service areas, consisting of a cover letter, brochure with descriptions of each of the MCOs, benefits and new features of *SoonerCare*, such as 6 months guaranteed eligibility and 12 month lock-in of enrollment, MCO provider directories, schedule of orientation meetings, postage-paid enrollment card and detailed instructions. Clients who desire additional information or need assistance will be invited to attend an orientation meeting in their area conducted by a member of the Client

Enrollment unit in the Authority's Managed Care Division. Beneficiaries will also be instructed to call Benova at the toll-free telephone number or the Client Enrollment unit if they have any questions.

Beneficiaries who heve previously been enrolled in MCOs will have the opportunity to change plans by either completing and returning the pre-addressed, postage paid enrollment card in the enrollment packet or calling Benova. Those who do nothing will remain in their current plan. Beneficiaries who were not previously in a plan will have the same options to make a selection. Those who do not select a plan will be assigned to one by the State using the auto-assignment algorithm.

Parents or guardians make a selection for all minor children. Families with more than one AFDC-related member eligible for services will be required to enroll all AFDC-related family members in one health plan. Newborn children will be enrolled automatically into their mother's plan retroactively effective to the date of birth. Families containing ABD beneficiaries will be permitted to select different health plans for their ABD members if these individuals have established relationships with providers who belong to the networks of competing plans or if more appropriate providers are available within a competing plan.

When MCOs begin operating under the 1115(a) waiver in July, 1996, the six month guaranteed eligibility will be measured from the eligibility date as calculated by the case worker at the most recent review. For instance, if a review was conducted in May for Medicaid eligibility beginning June 1, the recipient would have 5 months guaranteed eligibility remaining

Seriously Mentally Ill (SMI) and Seriously Emotionally Disturbed (SED) Enrollment

Due to the complexities of the determination and voluntary enrollment processes for adults determined to be suffering from a Serious Mental Illness (SMI) or children determined to be suffering from a Serious Emotional Disturbance (SED), Chapter 16 was developed to provide a comprehensive overview.

Disenrollment

Clients enrolled with a plan will have the right to request disenrollment, for cause, at any time. MCOs will also be permitted to request disenrollment of a member who is habitually non-compliant or who poses a threat to employees or other members of the health plan. In addition, MCOs will be able to request disenrollment with reliable documentation that the provider/client relationship has so deteriorated that continued service to a client would be seriously detrimental to the client, the provider/network, or both. For example, a plan might request disenrollment because of pending legal action related to the health plan/patient relationship. Final decision on disenrollment will be made by the State, in accordance with its Grievance & Appeals policies (see section 15).

Rural Enrollment Process

In rural areas, the State will first conduct a inree month tri-county pilot to ensure all **systems** are in place and functioning effectively (see additional information in section 1). Three contiguous counties have been selected for the pilot project: Hughes, Okfuskee and Seminole. PCCM contracts will be mailed to primary care providers in this area in mid-October. Subsequently, the Managed Care Division will educate the providers on

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the PCCM program during October and November, 1995. Meetings will be coordinated with DHS, the county medical societies, local hospitals and tribal facilities to ensure providers understand the contract terms and Agency policies in addition to answering any questions they may have. Providers may also contact the Health Care Authority's Provider Relations unit at a toll-free telephone number. All contracts must be returned by November 15.

The Managed Care Division will also conduct training sessions with the DHS county workers. The training consists of an introduction to managed care concepts, details of how the *SoonerCare* program works, a walk-though of a sample enrollment packet, the script for making the managed care offer to a recipient, and the procedures to record a recipient's PCCM selection. This training will be coordinated with the DHS county directors, and scheduled for the last week of November.

On December 1, a pre-enrollment notice will be mailed to all AFDC and AFDC related recipients in the pilot area as identified by DHS. The Enrollment Task Force, which consists of staff from the Health Care Authority, and several DHS state and county employees, is currently working on the wording for the notice.

Development and printing of the enrollment materials will be concurrent with provider education. The Marketing Liaison will be responsible for this activity. The enrollment packet will consist of a cover letter, an informational brochure describing the managed care changes, a "member handbook" which explains how to access different services, a provider directory, an enrollment card and detailed instructions. All pieces of the enrollment packet except the provider directory will be printed by December 1, 1995.

The provider directory will be printed by December 15. It will be sorted alphabetically by cities within each county and list:

- Provider's name
- Specialty
- Address
- Phone number
- Medicaid provider number
- Office hours
- Whether he/she is accepting new patients
- Hospital affiliations
- Languages spoken (other than English)
- Any other pertinent information, such as age limitations for pediatricians

All enrollment materials will be assembled into one packet for distribution to county offices on December 22. The packets will be mailed to all the AFDC and AFDC related eligibles in the three county area who recieved the pre-enrollment notice on January 2.

Recipients can indicate their first and second choice of Primary Care Case Manager (PCCM) either by mailing back the pre-addressed and stamped enrollment card included in their packet or by calling the enrollment agent. Whenever possible, the State will assign enrollees to their first choice. But in the event that provider reaches capacity, the second choice will be used. Benova will also answer questions recipients may have prior to choosing and encourage them to select a provider within 30 miles or **30** minutes of where they live.

The State is also exploring the feasibility of using Benova to place follow-up phone calls after the enrollment packets are mailed to increase the percentage of recipients making a selection. If no selection is made, or the first and second choice provider is not available, the recipient will be autoassigned to a provider within the same or a contiguous county, based upon capacity. Both the providers and recipients will be advised of enrollment via confirmations sent in mid- to late February. Service delivery will begin March 1.

Similarly, the AFDC and AFDC related populations in the remainder of the rural areas of the State will be receive a pre-enrollment notice March 1, be enrolled during an open enrollment in April, 1996 for PCCM service delivery effective June 1, 1996 (a complete implementation schedule is included at the end of this section).

Eligible ABD beneficiaries will be enrolled in the PCCM program by November 1, 1996. The same enrollment procedure will be used, but the information contained in the enrollment packet will specifically target this population. Also, the provider directory may be expanded to include sub-specialist internists and pediatricians. The enrollment packet will be mailed on September 1 to all Aged, Blind and Disabled eligibles in the rural areas who are not dually-eligible for Medicare, institutionalized, Severely Mentally Ill (SMI) or Seriously Emotionally Disturbed (SED) or receiving services under Home and Community-Based Waivers.

Significant outreach for the ABD populations in both urban and rural areas will be conducted by the Managed Care Coordinators and Client Enrollment Unit to educate recipients about the program and to assist them in enrollment. Group orientation meetings will be held at locations that are easily accessible and traditionally frequented by this population, such as senior citizen centers and churches. The State's toll-free telephone enrollment agent will also be available to provide information and assistance. In addition, as described in section 1, a number of resources are located within the State which will be used to supplement outreach and education.

After existing AFDC, AFDC-related, and ABD eligibles are enrolled, and Outpatient Networks are added, new applicants will be given the opportunity to "pre-select" a primary care provider or outpatient network at the time of eligibility application. Applicants will meet face-to-face with a case worker who will provide information describing the *SoonerCare* program and their providerhetwork options. During this session, the eligibility case worker will stress to applicants that actual enrollment with a provider or network will not occur unless and until a positive eligibility determination has

been made. For applicants who are determined eligible before the 15th day of the month, enrollment will become effective the first day of the next month. Those who are determined eligible the 15th of the month or later will be enrolled on the first day of the second month after determination. Prior to enrollment with a managed care provider, beneficiaries will be covered for the existing fee-for-service benefit package only. Any care provided to these individuals will be reimbursed by the State.

The provider(s) or network(s) offered to an individual either by his/her eligibility case worker or by mail will be determined based on his or her place of residence and distance to participating providers. Individuals who need more information prior to making a selection will be given a toll-free Member Services telephone number to call if and when they are ready to choose. As in the urban areas, Benova, Inc. will provide assistance in the enrollment implementation in the rural areas. The telephone lines will be manned by Member Service employees trained to assist beneficiaries in completing the selection process over the phone. Spanish-speaking operators will be available for applicants who speak Spanish as a first language. The program will have translation services available to assist applicants who speak languages other than English or Spanish. A TDD system will also be available for persons with impaired hearing.

Applicants will also be able to select a primary care provider or Outpatient Network by marking their choice on a pre-addressed and -stamped postcard. The State believes that by offering several methods for providerhetwork selection, it will minimize the number of cases in which individuals do not make a choice.

Regardless of the method used, all individuals will be required to select a provider or network and inform the State of their choice within ten business days of their application for eligibility or receipt of the enrollment materials. Those who do not select will be assigned to a provider or network from the pool of providers/networks with existing capacity.

The State will inform beneficiaries of their primary care providerhetwork by mail. The providerhetwork will also be notified by telephone, facsimile, or electronic data transmission. Prior to enrollment with a managed care provider, beneficiaries will be covered for the existing fee-for-service benefit package only. Any care provided to these individuals will be reimbursed by the State.

If an individual has enrolled with a primary care provider, the State will mail the "member handbook" developed for the pilot project which explains how to access services in the PCCM system. The monthly Medicaid card generated by DHS will contain the provider's name and telephone number, as well as the number for the State's toll-free Member Services line. It will also indicate any coverage limits, such as for prescriptions and hospital days. If an individual/family has enrolled with an Outpatient Network, the network will be required to mail a member handbook and inform the member about his or her primary care provider options and how to make a selection.

The Outpatient Network will also be required to issue an identification card within 10 days of enrollment which meets the State's standards and specifications. The card will include:

- The network's name
- Member's name
- Member's Medicaid identification number
- Toll-free telephone number for the member to call in the event of an urgent health care problem
- Name of primary care provider
- Provider's telephone number
- Instructions for emergency care

At the completion of the enrollment process, every individual will be linked with a primary care provider. Outpatient Networks will be required to assign members to a primary care provider if they do not choose one on their own, in accordance with the network's policies and procedures and State guidelines.

Special Enrollment Provisions

Under the 1115(a) waiver when a member (beneficiary) is enrolled with a PCCM or Network, they will be permitted to change PCCM or Network, without cause. At some future time, the State intends to restrict the beneficiary's ability to change PCCM or Network, without cause, as follows: When a beneficiary is initially enrolled with a PCCM or Network, they will be permitted to make a change within thirty (30) days, without cause. After the thirty-day window has expired, the beneficiary will remain enrolled with the provider/network unless and until:

- they lose eligibility
- they switch to a different providerhetwork during the next open enrollment period
- they move more than 45 miles or 45 minutes from the providednetwork or into an urban health plan service area
- they are disenrolled for cause (see below).

If a member moves more than 45 minutes or 45 miles from their providerhetwork, they will be disenrolled and autoassigned to a new provider/network based upon their new residence and capacity. If he/she moves from a rural area to an urban health plan service area they will be disenrolled from the provider/network and autoassigned to a health plan. The health plan would then contact the member regarding selection of a primary care provider. The member can change providers/networks/health plans within 30 days

After the initial enrollment period, open enrollment will be held once every twelve months. At that time, members will be given the opportunity to select a new providerhetwork from among those being offered. If the member does not select a different providerhetwork, he or she will automatically remain with their existing provider/network, with no interruption of coverage.

Individual members of a family will each be permitted to select a different primary care provider. Parents or guardians will select the providerhetwork for all minor children. Families with more than one AFDC-related member eligible for services who select an outpatient network will be required to enroll all AFDC-related family members into the same network. Newborn children similarly will be enrolled automatically into the network.

Families containing multiple ABD beneficiaries will be permitted to select different networks for their ABD members if these individuals have established relationships with providers who belong to competing organizations. In such circumstances, any AFDC/AFDC-related individuals in the family will be required, as a group, to join one of the networks selected by their Aged, Blind, and Disabled relatives. The purpose of this requirement is to preserve as much as possible the enrollment of families into managed care as a "single unit". Oklahoma believes the family unit principle promotes coordination of care for family members, while reducing the State's overall administrative burden.

Disenrollment

Clients enrolled with a providerhetwork will have the right to request disenrollment, for cause, at any time. Providers and networks will also be permitted to request disenrollment of a member who is habitually non-compliant or who poses a threat to employees or other patients. Providers will also be able to request disenrollment with reliable documentation that the provider/client relationship has so deteriorated that continued service to a client would be seriously detrimental to the client, the providerhetwork, or both. For example, a provider might request disenrollment because of pending legal action related to the provider/patient relationship. The final decision on disenrollment will be made by the State, in accordance with its Grievance & Appeals policies.

7. QUALITY ASSURANCE AND UTILIZATION REVIEW SYSTEM

Introduction

This section describes the quality assurance and utilization review system for urban and rural areas. It also includes the overall quality assurance monitoring plan the State will use for all health plans.

The draft version of Medicaid HEDIS, released in July of 1995, has been reviewed for inclusion into the QA/UR process. When it becomes available for use, it is the State's intention to incorporate it into several areas of both QA and UR under the direction of HCFA and in keeping with QARI. The QA areas for inclusion include replacing the documentation of focused studies identified in QARI Standard II as Clinical Areas of Concern, with Medicaid HEDIS Quality measures. All areas for focused studies selected by the State are included in the Medicaid HEDIS Draft under the Quality section. In addition the State will incorporate Medicaid HEDIS Membership, Access and Member Satisfaction, and General Plan Management into relevant QARI Standards. Medicaid HEDIS Utilization and Quality measures will also be used for utilization data in the State's utilization review system for all relevant UR measures.

Medicaid HEDIS is seen as an opportunity to obtain standardized documentation which can be used by both the plans and the State, not only for documentation purposes, but as an informational and educational tool to improve the quality and efficiency of Medicaid services.

MCO and Outpatient Network Monitoring

The State will rely on QARI standards for the MCO and Outpatient Network component under the 1115(a) waiver program. All QARI standards will be monitored for MCO and Outpatient Network managed care plans. MCO monitoring already has begun under the urban health plans participating in the 1915(b) waiver program.

Performance Monitoring

The State has in place effective procedures to monitor whether plans are following their own internal quality assurance plans and meeting other provisions of their State contracts. Also, under federal statute, the State will monitor the quality of services provided to Medicaid recipients. The monitoring process will be a two part process with a (1) baseline assessment and **(2)** an ongoing monitoring process.

Baseline Assessments

Internal quality assurance plans are effective only to the extent that plans comply with them. Since managed care plans are at varying levels of maturity, a baseline assessment of each plan's program was conducted at the time of project start-up. 'The baseline assessment tool used was one developed from ?he three-state QARI Demonstration Project. The State chose to monitor all sixteen QARI internal QAP Standards.

On-going Monitoring

As the system is implemented, the State has a responsibility for ensuring that health plans carry out an effective internal quality assurance program. Monitoring includes the review and analysis of data and narrative reports submitted by plans to the State (described below), on-site visits, review of medical records, grievance and satisfaction information, utilization and performance reviews, focused study reviews, and plan documentation on credentialling/recredentialling.

Monitoring will be at full compliance for standards documented as having all major components met in a baseline assessment of each plan. Monitoring will be of a phased in implementation plan for QARI standards documented as partially or not met in a baseline assessment of each plan. The QARI standards to be monitored are as follows:

Standards for Internal Quality Assurance Programs

There should be an effective and reliable mechanism whereby managed care organizations can monitor, evaluate, and take actions as necessary to improve care rendered by all providers acting on their behalf. Such a mechanism has been developed by leaders in the managed care industry and experts in quality assurance. It is the internal Quality Assurance Program (QAP). Internal QAPs consist of systematic activities, undertaken by the managed care organization itself, to monitor and evaluate the care delivered to its enrollees according to predetermined objective standards, and effect improvements in care, as needed.

It is recognized that not all managed care organizations currently meet these guidelines. Therefore, the State will work with plans during both the contract negotiation process and ongoing monitoring and evaluation of plan performance, to encourage and support full compliance (or phased-in compliance, if necessary; with the guidelines.

Standard I: Written QAP Description

The organization has a written description of its QAP. This written description meets the following criteria:

A. Goals & Objectives -

The written description contains a detailed set of QA objectives which are developed annually and include a timetable for implementation and accomplishment.

B. Scope-

1. The scope of the QAP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

2. The QAP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings [e.g., inpatient, ambulatory, (including care provided in private practice offices) and home care], and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)

C. Specific Activities - The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organization arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. Provider Review - The QAP provides for:

1. review by physicians and other health professionals of the process followed in the provision of health services; and

2. feedback to health professionals and MCO staff regarding performance and patient results.

F. Focus on Health Outcomes - The QAP methodology addresses health outcomes to the extent consistent with existing technology.

Standard 11: Systematic Process Of Quality Assessment & Improvement

The QAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

The QAP has written guidelines for its quality of care studies and related activities which include:

A. Specification of Clinical or Health Services Delivery Areas to be Monitored -

1. The monitoring and evaluation of care reflects the population served by the managed care organization in terms of age groups, disease categories, and special risk status.

2. For the Medicaid population, the QAP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These will be taken from among those identified by the Health Care Financing Administration's (HCFA's) Medicaid Bureau and jointly determined by the State and the managed care organization including the recommended clinical areas of concern of childhood immunizations and pregnancy.

3. At its discretion and/or as required by the State Medicaid agency, the organization's QAP also monitors and evaluates other important aspects of care and service.

B. Use of Quality Indicators - Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

2. For the priority areas selected by the State from the HCFA Medicaid Bureau's list of priority clinical and health services delivery areas of concern, the organization monitors and evaluates quality of care through studies which include, but are not limited to, the quality indicators also specified by the HCFA's Medicaid Bureau.

3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of Clinical Care Standards/Practice Guidelines -

1. The QAP studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified for each area identified in **'A'** above.

2. The standards/guidelines are based on reasonable scientific evidence and are developed or reviewed by plan providers.

3. The standards/guidelines focus on the process and outcomes of health care delivery, as well as access to care.

4. A mechanism is in place for continuously updating the standards/guidelines.

5. The standards/guidelines shall be included in provider manuals developed for use by MCO providers or otherwise disseminated to providers as they are adopted.

6. The standards/guidelines address preventive health services.

7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan.

8. The ***QAP*** shall use these standards/guidelines to evaluate the quality of care provided by the managed care organization's providers, whether the providers are organized in groups, as individuals, as IPAs, or in combinations thereof.

D. Analysis of Clinical Care & Related Services -

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service. For quality issues identified in the QAP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

2. Multi-disciplinary teams are used, where indicated, to analyze and address systems issues.

3. From 1 and 2, clinical related service areas requiring improvement are identified.

E. Implementation of Remedial/Corrective Actions - The QAP includes written procedures for taking appropriate remedial action whenever, as determined under the *QAP*, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;

2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;

3. specific actions to be taken;

4. provision of feedback to appropriate health professionals, providers and staff;

5. the schedule and accountability for implementing corrective actions;

6. the approach to modifying the corrective action if improvements do not occur;

7. procedures for terminating the affiliation with the physician, or other health professional or provider.

F. Assessment of Effectiveness of Corrective Actions -

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The managed care organization assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. Evaluation of Continuity & Effectiveness of the QAP -

1. The managed care organization conducts a regular and periodic examination of the scope and content of the *QAP* to ensure that it covers all types of services in all settings, as specified in STANDARD I-B-2.

2. At the end of each year, a written report on the QAP is prepared, which addresses: QA studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QAP.

3. There is evidence that QA activities have contributed to significant improvements in the care delivered to members.

The State of Oklahoma has selected Immunizations, pregnancy, EPSDT screens, and Asthma as focused studies for this QARI Standard. The Oklahoma Foundation for Medical Quality will be the external, independent review agent responsible for focused studies in conjunction with the plans and the Oklahoma Health Care Authority.

***Standard III: Accountability** To **The Governing** Body*

The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the managed care organization. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QAP - There is documentation that the Governing Body has approved the overall QAP and an annual QA plan.

B. Oversight Entity - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

C. QAP Progress Reports - The Governing Body routinely receives written reports from the QAP describing actions taken, progress in meeting QA objectives, and improvements made.

D. Annual QAP Review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess the QAP's continuity, effectiveness and current acceptability.

E. Program Modification - Upon receipt of regular written reports from the QAP delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within the managed care organization (MCO). This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance.

Standard** IV: **Active QA Committee

The QAP delineates an identifiable structure responsible for performing QA functions within the MCO. This committee or other structure has:

A. Regular Meetings - The structure/committee meets on a regular basis with specified frequency to oversee QAP activities. This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions, but in no case are such meetings less frequent than quarterly.

B. Established Parameters for Operating - The role, structure and function of the structure/committee are specified.

C. Documentation - There are records documenting the structure's/committee's activities, findings, recommendations and actions.

D. Accountability - The QAP committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

E. Membership - There is active participation in the QA committee from Health Plan providers, who are representative of the composition of the Health Plan's providers,

Standard V: QAP Supervision

There is a designated senior executive who is responsible for program implementation, The organization's Medical Director has substantial involvement in **QA** activities.

Standard VI: Adequate Resources

The QAP has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.

Standard VII: Provider Participation In The QAP

A. Participating physicians and other providers are kept informed about the written QA plan.

B. The MCO includes in all its provider contracts and employment agreements, for both physicians and non-physician providers, a requirement securing cooperation with the QAP.

C. Contracts specify that hospitals and other contractors will allow the managed care organization access to the medical records of its members.

Standard VIII: Delegation Of QAP Activities

The MCO remains accountable for all QAP functions, even if certain functions are delegated to other entities. If the managed care organization delegates any QA activities to contractors:

A. There is a written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the managed care organization.

B. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of **care** being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

Standard IX: Credentialling & Recredentialling

The QAP contains the following provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the MCO, are qualified to perform their services.

A. Written Policies & Procedures - The managed care organization has written policies and procedures for the credentialling process, which includes the organization's initial credentialling or practitioners, as well as its subsequent recredentialling, recertifying and/or reappointment of practitioners.

B. Oversight by Governing Body - The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialling function, has reviewed and approved the credentialling policies and procedures.

C. Credentialling Entity - The plan designates a credentialling committee or other peer review body which makes recommendations regarding credentialling decisions.

D. Scope - The plan identifies those practitioners who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, and other licensed independent practitioners included in the review organization's literature for members, as an indication of those practitioners whose service to members is contracted or anticipated.

E. Process - The initial credentialling process obtains and reviews verification of the following information, at a minimum:

1. the practitioner holds a current valid license to practice;

2. valid DEA or CDS certificate, as applicable;

3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable;

4. work history;

5. professional liability claims history;

6. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)

7. the practitioner holds current, adequate malpractice insurance according to the plan's policy;

8. any revocation or suspension of a state license or DEA/BNDD number;

9. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);

10. any sanctions imposed by Medicare andor Medicaid; and

11. any censure by the State or County Medical Association.

12. The organization requests information on the practitioner from the National Practitioner Data Bank and the State Board of Medical Examiners.

13. The application process includes a statement by the applicant regarding:

    a) any physical or mental health problems that may affect current ability to provide health care;

    b) any history of chemical dependency/substance abuse;

    c) history of loss of license andor felony convictions;

    d) history of loss or limitation of privileges or disciplinary activity; and

    e) an attestation to correctness/completeness or the application.

    This information should be used to evaluate the practitioner's current ability to practice.

14. There is an initial visit to each potential primary care practitioner's office, including documentation of a structured review of the site and medical record keeping practices to ensure conformance with the managed care organization's standards.

F. Recredentialling - A process for the periodic reverification of clinical credentials (recredentialling, reappointment, or recertification) is described in the organization's policies and procedures.

1. There is evidence that the procedure is implemented at least every two years.

2. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all physicians, to decide whether to renew the participating physician agreement. At a minimum, the recredentialling, recertification or reappointment process is organized to verify current standing on items listed in 'E-1' through 'E-7', above and item **'E-13'** as well.

3. The recredentialling, recertification or reappointment process also includes review of data from:

   a) member complaints;

   b) results of quality reviews;

   c) utilization management;

   d) member satisfaction surveys; and

   e) reverification of hospital privileges and current licensure.

G. Delegation of Credentialling Activities - If the managed care organization delegates credentialling (and recredentialling, recertification, or reappointment) activities, there is a written description of the delegated activities, and the delegate's accountability for these activities. There is also evidence that the delegate accomplished the credentialling activities. The managed care organization monitors the effectiveness of the delegate's credentialling and reappointment or recertification process.

H. Retention of Credentialling Authority - The managed care organization retains the right to approve new providers and sites, and to terminate or suspend individual providers. The organization has policies and procedures for the suspension, reduction or termination of practitioner privileges.

I. Reporting Requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

J. Appeals Process - There is a provider appellate process for instances where the managed care organization chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

Standard X: Enrollee Rights & Responsibilities

The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. Written Policy on Enrollee Rights - The organization has a written policy that recognizes the following rights of members:

   1. to be treated with respect, and recognition of their dignity and need for privacy;

   2. to be provided with information about the organization, its services, the practitioners providing care, and member rights and responsibilities;

3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners;

4. to participate in decision-making regarding their health care;

5. to voice grievances about the organization or care provided;

6. to formulate advance directives; and

7. to have access to his/her medical records in accordance with applicable federal and state laws.

B. Written Policy on Enrollee Responsibilities - The organization has a written policy that addresses members' responsibility for cooperating with those providing health care services. This written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff in caring for the member; and

2. following instructions and guidelines given by those providing health care services.

C. Communication of Policies to Providers - A copy of the organization's policies on members' rights and responsibilities is provided to all participating providers.

D. Communication of Policies to Enrollees/Members - Upon enrollment, members are provided a written statement that includes information on the following:

1. right: and responsibilities of members;

2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:

   a) any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system; and

   b) the procedures for obtaining out-of-area coverage;

3. provisions for after-hours and emergency coverage;

4. the organization's policy on referrals for specialty care;

5. charges to members, if applicable, including:

   a) policy on payment of charges; and

b) co-payment and fees for which the member is responsible;

6. procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site;

7. procedures for appealing decisions adversely affecting the members' coverage, benefits, or relationship to the organization;

8. procedures for changing practitioners;

9. procedures for disenrollment; and

10. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.

E. Enrollee/Member Grievance Procedures - The organization has a system(s), linked to the *QAP,* for resolving members' complaints and formal grievances. This system includes:

1. procedures for registering and responding to complaints and grievances in a timely fashion (organizations should establish and monitor standards for timeliness);

2. documentation of the substance of complaints or grievances, and actions taken;

3. procedures to ensure a resolution of the complaint or grievance;

4. aggregation and analysis of complaint and grievance data and use of the data for quality improvement; and

5. an appeal process for grievances.

F. Enrollee/Member Suggestions - Opportunity is provided for members to offer suggestions for changes in policies and procedures.

G. Steps to Assure Accessibility of Services - The managed care organization takes steps to promote accessibility of services offered to members. These steps include:

1. The points of access to primary care, specialty care, and hospital services are identified for members.

2. At a minimum, members are given information about:

a) how to obtain services during regular hours of operations;

b) how to obtain emergency and after-hours care; and

c) how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

H. Written Information for Members -

1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.

2. Written information is available, as needed, in the languages of the major population groups served. **A** "major" population group is one which represents at least 10% of a plan's membership.

I. Confidentiality of Patient Information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.

1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records,

2. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.

3. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:

a) it is required by law;

b) it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

c) it is necessary in compelling circumstances to protect the health or safety of an individual.

4. Any release of information in response to a court order is reported to the patient in a timely manner.

5. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

J. Treatment of Minors - The organization has written policies regarding the appropriate treatment of minors.

K. Assessment of Member Satisfaction - The organization conducts periodic surveys of member satisfaction with its services.

1. The surveys include content on perceived problems in the quality, availability, and accessibility of care.

2. The surveys assess at least a sample of:

a) all Medicaid members;

b) Medicaid member requests to change practitioners andor facilities; and

c) disenrollment by Medicaid members.

3. As a result of the surveys, the organization:

a) identifies and investigates sources of dissatisfaction;

b) outlines action steps to follow-up on the findings; and

c) informs practitioners and providers of assessment results.

4. The organization reevaluates the effects of the above activities.

Standard XI: Standardsfor Availoility ana Accessibility

The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these dimensions of access are assessed against the standards.

Standard XII: Medical Record Standards

A. Accessibility & Availability of Medical Records -

1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof.

2. Records are available to health care practitioners at ezch encounter.

B. Record keeping - Medical records may be on paper or electronic. The Plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

1. Medical Record Standards - The organization sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

a) Patient Identification Information - Each page or electronic file in the record contains the patient's name or patient ID number.

b) Personal/Biographical Data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.

c) Entry Date - All entries are dated.

d) Provider Identification - All entries are identified as to author.

e) Legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.

f) Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies---NU) is noted in an easily recognizable location.

g) Past Medical History (for patients seen three or more times) - Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history relates to prenatal care, birth, and family history.

h) Immunizations - For pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date.

i) Diagnostic Information

j) Medication Information

k) Identification of Current Problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

1) Smoking/ETOH/Substance Abuse - Notation concerning cigarettes and alcohol use and substance abuse is present (for patients 12 years and over and seen three or more times). Abbreviations and symbols may be appropriate.

m) Consultations, Referrals & Specialist Reports - Notes fiom any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

n) Emergency Care

o) Hospital Discharge Summaries - Discharge summaries are included as part of the medical record for: (1) all hospital admissions which occur while the patient is enrolled in the MCO and (2) prior admissions as necessary.

p) Advance Directive - For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

2. Patient Visit Data - Documentation of individual encounters must provide adequate evidence of, at a minimum:

a) History & Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.

b) Plan of Treatment

c) Diagnostic Tests

d) Therapies & Other Prescribed Regimens

e) Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems fiom previous visits are addressed in subsequent visits.

f) Referrals & Results Thereof

g) All Other Aspects of Patient Care (including ancillary services)

C. Record Review Process -

1. The MCO has a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards.

2. The record assessment system addresses documentation of the items listed in 'B' above.

*Standard XIII: Utilization **Review***

A. Written Program Description - The organization has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to detect under utilization as well as over utilization.

C. Pre-authorization & Concurrent Review Requirements - For organizations with pre-authorization or concurrent review programs:

1. Pre-authorization and concurrent review decisions are supervised by qualified medical professionals.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.

3. The reasons for decisions are clearly documented and available to the member.

4. There are well-publicized and readily available appeals mechanisms for both providers and patients. Notification of a denial includes a description of how to file an appeal.

5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

The State will monitor the following areas for Utilization Review through our contract with the external independent review organization, The Oklahoma Foundation for Medical Quality and through our contract with the University of Oklahoma College of Pharmacy for Drug Utilization Review.

-Inpatient hospital admission days
-Ambulatory surgeries
-Primary care encounters (physician and nonphysician practitioners)

-Specialty physician referrals
-EPSDT screens
-Emergency room encounters
-Pharmacy services
-Covered diagnostic procedures

Standard XIV: Continuity Of Care System

The MCO has put a basic system in place which promotes continuity of care and case management.

Standard XV: QAP Documentation

A. Scope - The MCO shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QAP. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)

B. Maintenance & Availability of Documentation - The MCO must maintain and make available to the State, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions.

Standard XVI: Coordination Of QA Activity With Other Management Activity

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels.

A. QA information is used in recredentialling, recontracting and/or annual performance evaluations.

B. QA activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

C. There is a linkage between QA and the other management functions of the Health Plan such as:

1. network changes;
2. benefits redesign;
3. medical management systems (e.g., pre-certification);
4. practice feedback to physicians;
5. patient education; and
6. member services.